Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-0923-01

MFDR Date Received
October 13, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "because Provider did request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A)."

Amount in Dispute: $6,769.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the medical dispute filed by Vista Hospital of Dallas for services rendered . . . The bill and documentation attached to the medical dispute have been re-reviewed and an adjustment has been made . . . Liberty Mutual believes that Vista Hospital of Dallas has been appropriately reimbursed for services rendered . . . "

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2009	Outpatient Hospital Services	$6,769.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets general provisions regarding the dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
4. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 15, 2008

   - B207 – THIS IS AN UNLISTED PROCEDURE. PLEASE RESUBMIT WITH A MORE DESCRIPTIVE CODE. (B207)
   - B291 – THIS IS A BUNDLED OR NON COVERED PROCEDURE BASED ON MEDICARE GUIDELINES; NO SEPARATE PAYMENT ALLOWED. (B291)
   - B406 – DOCUMENTATION NOT SUBMITTED OR INSUFFICIENT TO ACCURATELY REVIEW THIS BILL. (B406)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)

   Explanation of benefits dated October 27, 2009

   - Additionally, both the respondent and the requestor submitted copies of an explanation of benefits dated October 27, 2009. This date was after the filing of the medical fee dispute, which was received by the Division on October 7, 2009. Per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Accordingly, any new denial reasons presented in the explanation of benefits dated October 27, 2009 may not be considered in this review.

Issues

1. Is there an unresolved issue of medical necessity regarding services billed under procedure code 20926?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the respondent's position statement finds that there is an unresolved issue of medical necessity regarding services billed under procedure code 20926. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. §133.305(b) requires that if a dispute regarding medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021. The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted preauthorization approval letter finds that these services are not listed among the services that were preauthorized. No documentation was submitted to support that the issue of medical necessity has been resolved prior to the filing of the request for medical fee dispute resolution. Accordingly, the medical fee dispute regarding procedure code 20926 is not considered or addressed in this review.
2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g).

   The requestor's position statement asserts that "because Provider did request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A)." The Division notes that §134.403(f)(1)(A) provides for reimbursement at 200 percent of the Medicare facility specific reimbursement amount (and any applicable outlier payment amount) without separate reimbursement of implantables.

Review of the initially submitted medical bill finds that the health care provider did not request separate reimbursement of implantables. Review of the request for reconsideration bill finds a stamp marked "SEPARATE REIMBURSEMENT TO HOSPITAL OF IMPLANTABLES REQUESTED." However, review of the request for reconsideration letter from the healthcare provider to the insurance carrier finds no specific request for separate reimbursement of implantables. Rather, the request for reconsideration letter asks for "additional reimbursement of $6,715.26 that will equal to Medicare APC $5,730.59 rate x 200% = 11,461.18" indicating a request for the default reimbursement method. The Division concludes that the requestor failed to indicate to the insurance carrier a clear intent to request separate reimbursement of implantables.

Moreover, §134.403(f)(1) allows for separate reimbursement of implantables only if the request is in accordance with subsection (g). §134.403(g)(1) requires that the requestor "shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.'" Review of the submitted documentation finds no such certification. In the absence of certification, the requestor has not met the requirements of subsection (g).

After thorough review of all the submitted information, the Division finds that separate reimbursement of implantables was not requested in accordance with subsection (g). The Division concludes that the appropriate rule for reimbursement is §134.403(f)(1)(A). Consequently, reimbursement for applicable outpatient hospital services shall be calculated by multiplying the sum of the Medicare facility specific reimbursement amount, and any outlier payment amount, by 200 percent.

4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
   - Procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
   - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.31. 125% of this amount is $4.14
   - Procedure code 29888 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,714.62. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,879.13. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $1,929.00 yields a cost of $628.85. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,879.13 divided by the sum of all APC payments is 61.36%. The sum of all packaged costs is $4,864.41. The allocated portion of packaged costs is $2,984.91. This amount added to the service cost yields a total cost of $3,613.76. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total Medicare facility specific reimbursement amount for this line is $2,879.13. This amount multiplied by 200% yields a MAR of $5,758.26.

- Per Medicare policy, procedure code 29876 may not be reported with procedure code 29888 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment cannot be recommended.
- Procedure code 29881 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,079.64. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,812.89. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $906.45. This amount multiplied by 200% yields a MAR of $1,812.90.
- Per Medicare policy, procedure code 29882 may not be reported with procedure code 29876 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service with an appropriate modifier. Separate payment is allowed. Procedure code 29882 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,833.13. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,099.88. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,079.64. The non-labor related portion is 40% of the APC rate or $733.25. The sum of the labor and non-labor related amounts is $1,812.89. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $906.45. This amount multiplied by 200% yields a MAR of $1,812.90.
- Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94762 has a status indicator of Q, which denotes conditionally packaged services that may be separately payable only if OPPS criteria are met. However, the separate payment criteria are not met for this service. Payment for this service is included in the payment for the primary surgery billed on the same claim. The use of a modifier is not appropriate. Separate payment is not recommended.
- Per Medicare policy, procedure code 99205 may not be reported with procedure code 99234 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Per Medicare policy, procedure code 99234 may not be reported with procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.

5. The total allowable reimbursement for the services in dispute is $9,388.20. This amount less the amount previously paid by the insurance carrier of $9,534.00 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	June 28, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.